Clark County Health Department 517 Court Street, Room 105 | Neillsville, WI 54456

Phone: (715) 743-5105 | Fax: (715) 743-5115 | http://www.clarkcounty.wi.gov/healthdepartment

ADULT COVID-19 VACCINE ADMINISTRATION RECORD

Information collected on this form will be used to document authorization for receipt of a COVID-19 vaccine dose, and will be shared through the Wisconsin Immunization Registry (WIR). Information collected on this form is voluntary and confidential.

Please answer the following questions:	Yes	No
1. Is the vaccine recipient at least 18 years old?		
2. Is the vaccine recipient currently experiencing a moderate or severe acute illness with or without fever?		
3. Has the vaccine recipient been instructed by public health to isolate at this time due to COVID-19 infection?		
4. Has the vaccine recipient ever experienced a severe allergic reaction (hives, swelling, wheezing, or respiratory distress) requiring medical care or treatment with epinephrine (EpiPen) to: ▪ A previous dose of a COVID-19 vaccine ▪ A component of a COVID-19 vaccine, including Polyethylene glycol (PEG), which is found in some medications such as laxatives and preparations for colonoscopy procedures ▪ Polysorbate (which is found in some vaccines, film coated tablets, and IV steroids)		
5. Does the vaccine recipient have a history of a blood clotting condition, such as **heparin-induced thrombocytopenia (HIT)?**		
6. Does the vaccine recipient have a past or current diagnosis with MIS-C (Multisystem Inflammatory Syndrome in Children) or MIS-A (Multisystem Inflammatory Syndrome in Adults)?		
7. Does the vaccine recipient have a past or current diagnosis with myocarditis or pericarditis?		
8. Is the vaccine recipient immunocompromised (have a weakened immune system)?		

Information about the person to receive the COVID-19 vaccine dose (please print):

Last Name: **First Name:** **M.I.** **Age:**

Date of Birth Month: Day: Year: **Sex:** Male ☐ Female ☐ Other ☐

Ethnicity: Hispanic ☐ Not Hispanic ☐ **Race:** White ☐ African American ☐ Asian ☐ Other ☐

Address: Street, City, Zip Code **Phone #** **County**

I have answered the above questions to the best of my knowledge. I have been offered a copy of the COVID-19 fact sheet. I have had the chance to ask questions that were answered to my satisfaction.

I understand that if I have a dermal filler, I may experience temporary swelling at or near the site of the filler injection (usually face/lips) and will contact my healthcare provider if swelling develops.

If I am requesting the Janssen COVID-19 vaccine, I am aware that mRNA vaccines are preferred over the Janssen COVID-19 vaccine, and that there is a risk of *thrombosis with thrombocytopenia* (TTS) following receipt of the Janssen COVID-19 vaccine. I understand to seek medical attention immediately if I develop any of the following symptoms: shortness of breath, chest pain, leg swelling, persistent abdominal pain, severe or persistent headaches or blurred vision, or experience easy bruising or tiny blood spots under the skin beyond the site of the injection.

I have been made aware of the appropriate time I am expected to be monitored for post-vaccination reactions based on my risk factors. *If I am requesting an additional dose of the vaccine, I attest that I meet the eligibility criteria.* **I understand the benefits and risks of the vaccine requested and ask that the vaccine be given to me.**

By signing this form, I authorize the Clark County Health Department to release the necessary information to the insurance carrier indicated below, to process this claim. I understand I will not be held responsible to pay the COVID-19 vaccine administration fee, if my insurance carrier denies payment or if I have an insurance carrier that the CCHD does not accept.

Signature of person to receive the vaccine or authorized person: **Date:**

X _____

STOP - FOR CLINIC/OFFICE USE ONLY			
Vaccine Name ☐ MODERNA COVID-19 ☐ JANSSEN COVID-19	**LOT:** **EXPIRATION DATE:**	**Dose** ☐ 0.5 ML (FULL) ☐ 0.25 ML (HALF)	**Injection Site** **LD / RD**
Signature & Title of Vaccine Administrator:		**Date:**	
☐ **WIR** ☐ **Billed**			*Updated: 2.22.2022*
INSURANCE INFORMATION			
Primary Insurance Carrier Provider:			
Member ID / Subscriber or ID #:			
Secondary Insurance Carrier Provider (if applicable):			
Member ID / Subscriber or ID # for Secondary Insurance (if applicable):			